EXCERPT

The Bon Secours Hospital

Holden Coronary Care Unit

Grosse Pointe, Michigan

Sheila Le Sueur, R.N., Retired

Bon Secours Nurse from 1955-1977

Dandelion Books, LLC

Mesa, Arizona

Le Sueur, Sheila - The Bon Secours Hospital Holden Coronary Unit, Grosse Pointe, Michigan

ISBN 978-1-934280-83-6

Library of Congress Number 2010935514

Edited by Carol Adler, MFA @www.write-to-publish-for-profit.com
Prepared for Publication by Dandelion Books and "Meesh & Treesh," Sheila LeSueur's devoted nieces
Cover & Book Design by Acccurance@www.accurance.com

Disclaimer and Reader Agreement

Under no circumstances will the publisher, Dandelion Books, LLC, or author be liable to any person or business entity for any direct, indirect, special, incidental, consequential, or other damages based on any use of this book or any other source to which it refers, including, without limitation, any lost profits, business interruption, or loss of programs or information.

Though due diligence has been used in researching and authenticating the information contained in this book, Dandelion Books, LLC and the author make no representations as to accuracy, completeness, currentness, suitability, or validity of any opinions expressed in this book. Neither Dandelion Books, LLC nor the author shall be liable for any accuracy, errors, adequacy or timeliness in the content, or for any actions taken in reliance thereon.

Dandelion Books, LLC

www.dandelion-books.com

2

The November Miracle

On Saturday afternoon, November 19, 1966, Mr. N, a 59-year-old reporter for one of Detroit's daily newspapers, came to the emergency room complaining that he wasn't feeling well. His health history was riddled with red flags. He was overweight, a diabetic, and a smoker. The pressure of always rushing to meet deadlines was highly stressful; apparently it was starting to take its toll.

Dr. Dwight Dutcher, his attending physician, had ordered an electrocardiogram. Since the tracings failed to reveal any cardiac damage, he was discharged.

As he was being wheeled out to his car, he began to perspire profusely and complained of chest pains. He was rushed back to the Emergency Room where a repeat cardiogram detected an arrhythmia requiring defibrillation, an electric shock, to restore his heartbeat. The second cardiogram revealed that he had sustained an acute myocardial infarction.[1]

Such events are possible and not as rare as they may seem. Yet they beg the question: why hadn't the patient been admitted when he'd first arrived in the ER? The rudimentary information that could be gathered at that time did not indicate a serious problem.

---

[1] Myocardial infarction (MI) or acute myocardial infarction (AMI), commonly known as a heart attack, is the interruption of blood supply to part of the heart, causing heart cells to die. This is most commonly due to occlusion (blockage) of a coronary artery following the rupture of a vulnerable atherosclerotic plaque, which is an unstable collection of lipids (fatty acids) and white blood cells (especially macrophages) in the wall of an artery.

The most important part of any examination is the patient's history. Unfortunately, at that time smoking and obesity were not yet recognized as killers.

Once Mr. N's condition was stabilized, he was transferred to Bed 2 in the Intensive Care Unit.

The unit was staffed with two RN's during the day and afternoon shifts, and one on the night shift. On Monday, November 21, I arrived for my shift at 7AM and listened to the report from the night nurse. Then we began our routine morning activities of checking vital signs and serving a light breakfast.

Around 10 AM, Mr. N's condition changed. He turned ashen and lost consciousness. One of us paged Code 99.[2] Within seconds, Dr. Dutcher responded, followed closely by cardiologist Dr. Robert Griffin and the EKG technician with the Sanborn EKG machine[3], which was our major diagnostic device at that time.

Dr. Griffin confirmed the diagnosis of an acute myocardial infarction and proceeded to give him a shock. Nothing. He repeated it with the same ineffective result.

Then he handed the paddles to me, saying, "You try."

I was startled, since I'd never thought that one day this procedure would be part of my nursing responsibilities. Instinctively I knew I didn't want to say no, so I clutched the

---

2 Code 99 is the term used to activate a timely response to medical emergencies *and/or* situations requiring cardiopulmonary resuscitation (CPR). Resuscitation measure will be initiated immediately on any person determined to be pulse-less and/or apneic unless there is a written physician's order on the patient's medical record to withhold CPR.

3 Electrocardiography - the harnessing of electricity, observations of its effects on animal tissues and the discovery of "animal electricity"; in 1928 - Frank Sanborn's company (founded 1917 and acquired by Hewlett-Packard in 1961 and since 1999, Philips Medical Systems) converted their table model electrocardiogram machine into their first portable version weighing 50 pounds and powered by a 6-volt automobile battery.

paddles and administered the third shock. This was a unique experience; I was so nervous, afterward I didn't even remember doing it.

I asked Dr. Griffin if I could repeat it.

"Sure, go ahead!" he said.

I gave the shock and the patient lived six more years.

Following the defibrillation, Mr. N. developed severe cerebral anoxia. For two full days and nights he was wildly confused, restless, and noisy.

On the third day, "he arose again," alert and oriented.

Mr. N.'s return to life as a result of the implementation of new medical techniques became known as the November Miracle.

This event and its successful outcome confirmed what the medical journals were beginning to describe as specialized care for cardiac patients. Research estimated that as many as 50,000 victims could be saved annually if all victims could reach a hospital Coronary Care Unit.

Most patients who suffered a heart attack never made it to the hospital. A heart attack was a highly dreaded illness, something people read about in the obituaries. In this era, the best one could anticipate was retirement at age sixty-five and hope for the best.

Statistics tell us that too often patients retired and died. Pension schemes were set up with such an expectation.

In 1966, before cardiac care units, coronary patients were cared for on the general floors. Respiratory therapy departments had not yet been developed, monitors did not exist and

other systems and tools were minimal. Also, we could not regulate a patient's IV (intravenous flow). Our choices were limited to either turning on or off the flow through the tubing. Lidocaine was still unknown to us and pacemakers[4] had not yet been perfected.

We did have oxygen and Morphine was the drug of choice for relieving severe pain for which Demerol was ineffective.

It was not uncommon to find patients dead in bed even directly after the nurse had left the room. When this happened, a nurse was bound to feel guilty. I have my own memories of at least one such event and I know I could not have prevented it. The electrical system of the cardiac cycle is magnificent but it can be fickle. It only takes one beat to go awry—*only one beat!*

We nurses were in awe of the defibrillator, the "doctor's gadget," and that was the extent of our equipment. All we had to rely on was delivery of expert nursing care.

Since nurses were on duty around the clock, patients and their families could count on our presence. Sometimes they felt more comfortable addressing their questions to us rather than the physicians, so we also acted as intermediaries.

When working with cardiac patients, our nursing skills were put to test in new and different ways. Although we didn't know it at the time, Bon Secours nurses excelled in providing the type of care that often was unavailable at other hospitals.

[4] In the late 1960s, several companies, including ARCO in the USA, developed isotope powered pacemakers, but this development was overtaken by the development in 1971 of the lithium-iodide cell by Wilson Greatbatch. Lithium-iodide or lithium anode cells became the standard for future pacemaker designs. A further impediment to reliability of the early devices was the diffusion of water vapor from the body fluids through the epoxy resin encapsulation affecting the electronic circuitry. This phenomenon was overcome by encasing the pacemaker generator in an hermetically sealed metal case, initially by Telectronics of Australia in 1969 followed by Cardiac Pacemakers Inc of Minneapolis in 1972. This technology, using titanium as the encasing metal, became the standard by the mid-1970s. —Wikipedia, http://en.wikipedia.org/wiki/Artificial_pacemaker

Nurses at Bon Secours were not assigned to work with cardiac patients; they had to make the request themselves. Many of the Bon Secours nurses realized they were not cut out for it. For “Nurse Sheila LeSeuer,” however, it was perfect. I enjoyed the challenge.